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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/27/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
outpatient right shoulder arthroscopy subacromial decompression distal clavicle excision and possible rotator cuff repair

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
M.D., Board Certified Orthopedic Surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute. The reviewer finds medical necessity is not established for outpatient right shoulder arthroscopy subacromial decompression distal clavicle excision and possible rotator cuff repair.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
ODG - Official Disability Guidelines & Treatment Guidelines
Utilization review determination 07/11/12
Utilization review determination 08/06/12
MRI right shoulder 04/07/10
Clinical records Dr. 04/27/10-06/21/12
Designated doctor evaluation 04/22/11
Radiographic report lumbar spine 06/06/12
Clinical note Dr. 07/31/12

PATIENT CLINICAL HISTORY [SUMMARY]:
This review is for a female who is reported to have sustained work related injuries on xx/xx/xx. She had an MRI of the right shoulder dated 04/07/10. The study reports a type 2 SLAP lesion involving the anterior, superior and labral complex. Tenosynovitis of the long head of the bicipital tendon with minimal subcoracoid bursitis. There is no evidence of a partial or full thickness rotator cuff tear. There are hypertrophic changes of the AC joint with some moderate buttressing against the supraspinatus muscle and tendon. The claimant was seen by Dr. on 04/27/10. He notes that the claimant fell forward sustaining an injury to her right shoulder and neck. She reports numbness and tingling over the hand. MRI was discussed and conservative management of her injury was recommended, to include a home exercise program and intraarticular corticosteroid injection. When seen in follow up on 05/25/10 she reported improvement and was noted to be making significant progress. She received a second corticosteroid injection on 06/15/10. On 04/22/11, she was seen by Dr., a designated doctor. Dr. notes that the claimant complains of constant pain in her right arm, shoulder, hand, neck, back, right leg, and foot. He notes reduced range of motion. On physical examination Spurling's test is negative, Neer's test was negative, Hawkins' test was negative, and cross body adduction was negative. It was his opinion that the claimant had not reached maximum medical improvement. He reports that she has a documented C5 radiculopathy by EMG and that MRI shows a large disc protrusion. The claimant is noted to

have a C5 sensory loss. The designated doctor wrote that he agreed with Dr.'s recommendation for cervical spine surgery.

The claimant was examined by Dr. on 06/21/12. At this exam, she reports progressively worsening symptoms in her shoulder. She is noted to be status post cervical fusion. On physical examination the claimant is reported to have a positive impingement sign, positive cross arm adduction test, crepitation in the subacromial space, elevation to 150 degrees, external rotation to 45 degrees, internal rotation to L3. Surgical intervention is recommended.

The initial review was performed by Dr. on 07/11/12 Dr. non-certified the request. She notes that there is a lack of documentation to substantiate failure of conservative management. MRI does not confirm the patient's rotator cuff tear.

The claimant was seen on 07/24/12. It is noted that surgical intervention was not authorized secondary to no substantial conservative care. The provider notes that the claimant has undergone a home exercise program and also formal supervised physical therapy without relief. In addition, she has undergone three cortisone injections without sustained benefit.

An appeal request was reviewed by Dr. on 08/06/12. Dr. non-certified the request noting that the radiologist analysis of recent imaging studies was not provided for review. He reports there is no evidence of failure of non-operative management to include physical therapy, activity modification, and home exercise program. He further notes that there are no physical therapy records regarding the numbers of completed session sessions.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

The submitted clinical records indicate that the claimant sustained injuries to her shoulder and neck as a result of a slip and fall. It would appear that the claimant's neck symptoms were bothering her more than the shoulder symptoms and she was ultimately taken to surgery and appears to have undergone a single level ACDF. The patient had continued complaints of right shoulder pain that are reported to be refractory to conservative management. However, the clinical records fail to provide supporting documentation establishing this as a fact. In the records it suggests that the claimant has received corticosteroid injections and a home exercise program. There are no recent clinical records, which indicate that the claimant has actively participated in a recent rehabilitation program. Therefore, and noting the lack of documentation to establish the failure of all conservative management, the request would not meet Official Disability Guidelines criteria. Because of this, the reviewer finds medical necessity is not established for outpatient right shoulder arthroscopy subacromial decompression distal clavicle excision and possible rotator cuff repair.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[ ] ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
[ ] AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
[ ] DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
[ ] EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
[ ] INTERQUAL CRITERIA
[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
[ ] MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
[ ] MILLIMAN CARE GUIDELINES
[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
[ ] PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
[ ] TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
[ ] TEXAS TACADA GUIDELINES
[ ] TMF SCREENING CRITERIA MANUAL
[ ] PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
[ ] OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)